

FORSCOM ARMS GUIDE

H-Aviation Medicine

VERSION 9, EFFECTIVE 1 OCTOBER 2004

A-COMMAND FACTORS

QUESTION	QUESTION TEXT	REFERENCE TEXT	INSPECTION TECHNIQUE
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1.00

Are corrective actions taken on deficiencies noted on previous evaluations of the aviation medicine program? (AR 1-201, para 2-2e) (AU)

2-2e. *Followed up.* Inspections expend valuable resources and are not complete unless the inspecting unit or agency develops and executes a follow-up inspection or plan to ensure the implementation of corrective actions. Likewise, the inspected unit must develop and execute a corrective-action plan that fixes those problem areas identified during an inspection. Follow-up actions can include re-inspections, telephone calls (or visits) to units or proponents to check on the progress of corrective actions, or a request for a formal response from a unit or proponent that attests to the completion of the corrective action. To reduce the administrative burden on inspected units, a formal response to inspection reports is optional unless specifically requested.

Look for corrective action taken on previous evaluation in particular the previous ARMS.

2.00

Does the flight surgeon conduct aviation accident prevention surveys (AAPS) in the area of aviation medicine and kept them on file? (AR 40-3 Para. 3-6a (6)), AR 385-95 Para. 3-2(AU)

Para 3-6a (6) Conduct a semiannual accident prevention survey of the AVMED Program as required by AR 385-95. AR 385-95 Para. 3-2 a. Commanders of all active component aviation units and reserve component aviation support facilities will conduct AAPSS semiannually, at a minimum. Commanders of all other units will conduct AAPSS annually, at a minimum. "Guide to Aviation Resource Management for Aircraft Mishap Prevention" or a similar guide should be used as a reference. When possible, the AAPS should be administered from the battalion/squadron level consolidating the safety staff into a survey team and using supplemental expertise from outside the unit. b. Surveys conducted by external sources (brigade, installation, or MACOM aviation resource management surveys; standard Army safety and occupational health inspections; regional accident prevention surveys) may count toward semiannual accident- prevention surveys, provided all applicable functional areas for the organization are surveyed. An external survey may count toward the annual requirement for Reserve component units. The AAPS may be concurrent with internal command inspection programs as long as all unit functional areas are surveyed. c.The AAPS is a major source in the hazard identification step of the risk management process.

Check surveys to determine if the requirement has been met.

3.00

Are hazards found during the AAPS, in the area of aviation medicine, listed on the unit's hazard-tracking system? (AR 385-95, Para. 3-2c) (AU)

Para. 3-2c The AAPS is a major source in the hazard identification step of the risk management process. All hazards identified during the AAPS must be

thoroughly assessed for their risk level, and control options must be developed for command decision-making and implementation. Hazards found during the AAPS will be tracked through the unit hazard tracking system.

Check the unit's hazard tracking system for noted aviation medicine hazards.

4.00

Are the authorized number of flight surgeons assigned (authorized and required) IAW AR 616-110, para 11, a, b. If not, is the shortage listed on the USR? (AR 220-1) (AU)

Para. 11. The role of Army Aviation Medicine is to support Army aviation's mission. Flight surgeon requirements are determined by the number of aviation personnel supported, with the ratio of 250 aviation personnel per one flight surgeon generally not to be exceeded. Aviation personnel include individuals on operational and non-operational status within the area supported by the flight surgeon. Variables such as size, number, and location of units supported, frequency of deployment, mission requirements, and area support requirements may increase the number of flight surgeons required to conduct the Aviation Medicine Program. Questionable cases will be submitted for review by TSG (HSXY-AER) or the Chief, National Guard Bureau (ARNG-OAC). a. Flight surgeons are required in the table of organization and equipment (TOE) of aviation battalions or squadrons and larger units to provide advice on medical matters to the commanders and to provide medical treatment for assigned unit personnel. b. Flight surgeons, SSI 61N, are required in tables of distribution and allowances (TDA) as follows: (1) Medical section of headquarters elements at installations which provide medical support for Army aviation operations, regardless of size. (2) Staff sections of major command headquarters in the position of aviation medicine consultant. (3) Faculty positions at selected U.S. Army schools. (4) Staff positions at selected U.S. Army medical research and development activities. (5) Staff positions in selected Department of Army supervised activities. (6) Staff positions in the Office of The Surgeon General (TSG), Department of the Army. (7) Clinical positions in medical treatment facilities for the purpose of providing aero medical consultation and/or aviation medicine support.

Check organization and determine if appropriate flight surgeons are assigned.

5.00

In units without an authorized or assigned flight surgeon, do the local medical treatment facility (MTF) Commander, and the Command Surgeon (MACOM, USARC or State Surgeon) provide personnel and equipment for the Army Aviation Medicine Program at the local level? (AR 385-95, Para. 1-6g, AR 616-110, Para. 12b) (AU)

Para. 1.6. G Flight surgeon. g. Flight surgeon. The flight surgeon assists and advises the command in all aviation medical matters. In remote areas where a flight surgeon is not assigned or readily available, local support will be provided by the servicing medical department activity (MEDDAC) to best accomplish these duties. The flight surgeon will; (1) Maintain liaison within the command to implement the aviation medicine program. (2) Take part in, and observe, flight operations to monitor the interactions of crewmembers, aircraft, and environment. The flight surgeon exerts maximum effort in observing the flying ability and characteristics of each assigned aviator at least annually. (3) Serve as a member of aircraft accident investigations board, when directed. (4) Serve as a member of flight evaluation boards, when directed. (5) Ensure that the medical portion of the pre-accident plan is adequate. (6) Monitor the physical and mental health of aviation personnel, including alcohol abuse and self-medication problems, and advise the commander on crew-endurance issues. (7) Maintain aviation medical records on flight personnel, assist the unit in providing annual occupational health and safety screening for non-crewmember personnel, and ensure that DA Form 4186 (Medical Recommendation for Flying Duty) prepared on flight personnel is accurate and complete prior to being sent to the unit commander for approval. (8) Monitor the survival and physiological training of aviation crewmembers and provide medical support in accordance with applicable Army regulations. (9) Medically clear crewmembers for further flight duty after aircraft accidents in accordance with applicable Army regulations. (10) Make recommendations to the Commander, USASC, for improvement of human factors compatibility, crashworthiness, aviation life-support equipment, and survival features of aircraft. (11) Take part in aviation safety meetings to educate aviation crewmembers on the aeromedical aspects of flight. (12) Monitor the ALSE program. (13) Assist in, and advise on, the hearing and occupational vision program. (14) Ensure command consideration of preventive and occupational medicine aspects of all plans,

operations, training, and security missions.

Check to see if aviation medicine program requirements are being met without a flight surgeon.

*6.00

Does the commander suspend pay for non-rated crewmembers with overdue flight physicals (Flying Duty Medical Examinations (FDME's)) and administratively suspend these crewmembers from flying duty? (AR 600-106, Para. 2-7(2)) (AU)

Para. 2-7 (2) Soldiers who have not had a current valid medical examination as stated in AR 40-501 will be automatically suspended from flying status. The suspension will be effective on the date their medical examination expires. Commanders will notify the servicing Finance and Accounting Office when non-rated Army aviation personnel have been suspended from flying status.

Check for overdue flight physicals of non-rated personnel.

7.00

Does the Flight Surgeon or unit track FDMEs from initiation until posted in the Health Record with a final disposition from USAAMA? (AR 40-501, para 6-10f) (AU)

6-10f. Tracking. The flight surgeon or aviation unit will track FDMEs from initiation until posted in the health record with a final disposition by USAAMA. If disqualified, the flight surgeon and aviation unit will take action as per AR 600-105.

Check for written procedures to assure FDMEs are tracked.

8.00

Are written procedures in place whereby air crewmembers are automatically grounded when treated in an emergency center or specialty clinic? (AR 40-3, para 3-5d (3)) (AU)

3-5d. Aeromedical consultation. The FS will—(1) Ensure that an on-call service for aeromedical emergencies and aeromedical evacuation consultations is in place during all hours of flight operations. (2) Interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly. (3) Establish procedures whereby air crewmembers are automatically grounded when treated in the emergency center (EC) or specialty clinic. Protocols should then require grounded air crewmembers to report to the FS as soon as reasonably possible.

Check for written procedures to automatically ground crewmembers when they receive emergency treatment.

*9.00

Are rated crewmembers administratively restricted (grounded) from flying duties and considered for a non medical disqualification (DQ) and Flight Evaluation Board when the flight physical Flying Duty Medical Examination (FDME) expires? (AR 600-105, Para. 6-1(2)) (AU)

Para. 6-1(2) Failure to maintain medical certification. All officers, regardless of component or whether or not assigned to operational flying duty assignments must maintain medical certification for flying duty through timely physical examinations (AR 40-501). If the certification expires, the officer is unfit until medically qualified or a temporary medical extension is provided. Aviation service is suspended effective the day following the last day of his or her birth month. In cases where temporary medical extension has been provided, aviation service is suspended on the first day following the last day of the extension. The immediate commander will temporarily suspend the officer from flying duty. (a) If not physically examined and medically recertified within 180 days following the date of

suspension, the proper appointing authority will convene an FEB. (b) If the officer is given a physical examination within 6 months of suspension and the examination shows that the officer is unfit and will not be fit by the 181st day following suspension, the flight surgeon will inform the commander and USAAMC. USAAMC will act on the medical report. If disqualification is recommended, CDR, PERSCOM or CNGB will publish an aviation service order disqualifying the officer from aviation service. The effective date of this action will be the 181st day following suspension. (c) Officers must plan for timely completion of their physical examination and medical recertification. They must consider additional time for processing medical waivers. When an officer is stationed in a remote area and only limited facilities are available, or when other unexpected circumstances prevent a timely physical examination and medical recertification, an officer may request extension of eligibility up to 6 months as an exception. The officer will send a memorandum through his or her commander to the FEB appointing authority. The FEB appointing authority approves or disapproves the request.

Check for overdue flight physicals and determine if appropriate actions are documented.

10.00

Are Department of the Army Civilian (DAC) pilots, contract pilots, civilian Air Traffic Control (ATC) personnel, and Wage Grade 11 (WG-11) personnel maintaining valid Army Flying Duty Medical Examinations (FMDEs)? (AR 40-501, Para. 4-2) (AU)

4-2. Classes of medical standards for flying and applicability The classes of medical fitness standards for flying duties are as follows: a. Class 1 (warrant officer candidate) or Class 1A (commissioned officer or cadet) standards apply to— (1) Applicants for aviator training. (See also AR 611-85 and AR 611-110.) (2) Applicants for special flight training programs directed by DA or NGB, such as Army ROTC or USMA flight training programs. (3) Other non-U.S. Army personnel selected for training until the beginning of training at aircraft controls, or as determined by Chief, Army Aviation Branch. b. Class 2 standards apply to— (1) Student aviators after beginning training at aircraft controls or as determined by Chief, Army Aviation Branch. (2) Rated Army aviators (AR 600-105). (3) DAC pilots and contract civilian pilots who are employed by firms under contract to the DA that conduct flight operations or training, utilizing Army aircraft or aircraft leased by the Army. (See para 4-31.) (4) Army aviators considered for return to aviation service. (5) Senior career officers. When directed by DA or NGB under special procurement programs for initial Army aviation flight training, selected senior officers of the Army may be medically qualified under Army Class 2 medical standards. (6) Applicants to DA or NGB civilian-acquired aeronautical skills programs. (7) Other non-U.S. Army personnel. c. Class 2F standards apply to— (1) FSs (AR 600-105) and APAs. (2) Medical officers, medical students, and physician assistants applying for or enrolled in the Army Flight Surgeon's Primary Course or Army Aviation Medicine Orientation Course. d. Class 3 standards apply to non-rated (AR 600-106) soldiers and civilians ordered by a competent authority to participate in regular flights in Army aircraft, but who do not operate aircraft flight controls. These include crew chiefs, aviation maintenance technicians, aerial observers, gunners; unmanned aerial vehicle operators (UAVO), nonrated (AR 600-106) medical personnel selected for aeromedical training, such as flight medical aidmen, psychologists, dentists, and optometrists; and others. (See para 4-32.) e. Class 4 standards apply to Army military ATCs. (See paragraph 4-33b for standards for Army military ATCs. See paragraph 4-33a for the standards that apply to DAC ATCs and civilian ATCs employed under contract by DA or by firms under contract to DA.)

Check to ensure all applicable personnel maintain a current FMDE.

11.00

Are non-operational aviators completing annual flight physicals? (AR 600-105, Para. 3-1, c) (AU)

Para. 3-1, c All aviators and flight surgeons, whether or not assigned to operational flying duty positions, must meet class 2 medical fitness standards for aviators and class 2F medical fitness standards for flight surgeons for flying duty (AR 40-501) and be issued a medical clearance on DA Form 4186, Medical Recommendation for Flying Duty. Flight surgeons who resigned from aviation service (AR 616-110) or who have been terminated from aviation service by TSG; CDR, ARPERCEN; or CNGB, are not required to maintain class 2F medical certification.

Check to ensure all applicable personnel maintain a current FMDE.

*12.00

Do individual Flight Records contain a properly completed DA Form 4186 (medical clearance for flying or medical restriction from flying)? (AR 40-501, Para. 6-11,d) (AU)

Para. 6-11d. Each item of the DA Form 4186 will be completed as directed by the Commander, USAAMC. Three copies of the DA Form 4186 will be completed. ... Copy 2 is forwarded to the examinee's unit commander who signs and forwards it to the flight operations officer for inclusion in the flight records (AR 95-1 and FM 1-300). Copy 3 is given to the examinee

Check 4186s for currency.

13.00

Do individual Flight Records contain applicable medical waiver recommendations and approval letters? (AR 40-501, para 6-10g) (AU)

g. Disposal of documentation. Waiver and suspension recommendation and approval letters will be filed in the individual health record and flight record.

Check records for applicable waivers and approval letters.

14.00

Are extensions granted for flight physicals prior to the expiration date of the current physical (One time 30 day is the maximum)? (AR 40-501, Para. 6-11, i) (AU)

Para. 6-11, i. The validity period of the current FDME may be extended for a period not to exceed 30 days on DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME and be medically qualified or be: (1) administratively restricted from flying duties if no aero medical DQ exists and be considered for a non-medical DQ and FEB. (2) Medically restricted from flying duties if an aero medical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186.

Check extensions for correct dates.

*15.00

Are crewmembers performing aviation duties with expired physicals or extensions? (AR 95-1, Para. 2-1b; AR 40-501 Para. 6-11i) (AU)

Para. 2-1b. All Army aviators who are in aviation service per AR 600-105 must meet the annual physical requirements of AR 40-501 regardless of assignment. AR 40-501 Para. 6-11i. The validity period of the current FDME may be extended for a period not to exceed 30 days on DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME and be medically qualified or be— (1) Administratively restricted from flying duties if no aero medical DQ exists and be considered for a non-medical DQ and FEB (AR 600-105). (2) Medically restricted from flying duties if an aero medical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186

Look for expired flight physicals.

16.00

Does the unit's aero medical training program comply with the following references? (AR 95-1 Para. 4-14, 8-1g, AR 385-95, Para. 1-6g(11), FM 3-04.301, Para. 1-9,1-10, 1-11) (AU)

Para. 4–14 Flight crew members will receive aero medical and low pressure/high altitude training per the appropriate ATM and TC 1-210. g. Flight surgeons and aero medical advisors are responsible for— (1) Physiological training of aircrew personnel. (2) Medical aspects of survival training of aircrew personnel. (3) Monitoring the fitting and use of ALSE by aircrew personnel. g. Flight surgeon. The flight surgeon assists and advises the command in all aviation medical matters. In remote areas where a flight surgeon is not assigned or readily available, local support will be provided by the servicing medical department activity (MEDDAC) to best accomplish these duties. The flight surgeon will:... (11) Take part in aviation safety meetings to educate aviation crewmembers on the aero medical aspects of flight. CONTINUOUS TRAINING 1-9. The requirement for continuous training applies to all U.S. Army aircrew members in operational flying positions. The POI must be conducted in intervals of three years or less. When personnel turnover is high, a two-year cycle is recommended. The following subjects are the minimum training necessary for the unit to obtain adequate safety and efficiency in an aviation environment: Altitude physiology. Spatial disorientation. Noise in Army aviation. Night vision. Illusions of flight. Stress and fatigue. Protective equipment. Health maintenance. Toxic hazards in aviation. SPECIAL TRAINING 1-10. The unit commander must evaluate the missions of the unit to determine its special aero medical training requirements. This analysis should include the following: Combat mission. Installation support missions. Contingency missions. Past requirements. Geographic and climatic considerations. Programmed training activities. 1-11. The supporting flight surgeon will help identify the aero medical factors present during the various flight conditions and their effect on aircrews' performance. The flight surgeon and the unit commander will then develop a POI that meets the specific needs of the unit. 1-12. Commanders will include all crew members in the unit aero medical training program. Without proper training and experience, the crew member may not understand individual limitations and the risks involved in the aviation environment.

Check to ensure appropriate aeromedical training is conducted in the organization.

17.00

Has a mission analysis been conducted to determine special aero medical training requirements? (FM 3-04.301, Para. 1-10) (AU)

Para. 1-10. The unit commander must evaluate the missions of the unit to determine its special aero medical training requirements. This analysis should include the following; Combat mission. Installation support missions. Contingency missions. Past requirements. Geographic and climatic considerations. Programmed training activities.

Check for documentation indicating a mission analysis has been conducted to determine training requirements.

18.00

Do aircrew members and DOD civilians who fly in pressurized aircraft or in aircraft that routinely exceed 10,000 ft MSL receive hypobaric training? (FM 3-04.301, para 1-3) (AU)

1-3. Crew members and Department of the Army civilians who fly in pressurized aircraft or in aircraft that routinely exceed 10,000 feet MSL receive hypobaric training. Refresher training is conducted once every three years. The aviators trained are those who fly in pressurized aircraft or in aircraft that routinely exceed 10,000 feet MSL.

Check applicable records for the required training.

19.00

Does the Flight Surgeon assist the unit Aircrew Life Support Equipment shop with Class VIII support and survival education? (AR 40-3, para 3-5b (3)) (AU)

b. Preventive medicine/occupational health. The FS will—(1) Promote the health and safety of aviation personnel by instituting a health education program and monitoring the conditions and hazards present in the work environment. The FS will advise the command when potential safety problems are identified through participation in the Aviation Command Safety Council Program (per AR 385–95). (2) Monitor aviation occupational hazards in accordance with established Army programs such as the Hearing Conservation Program and the Occupational Vision Program, as described in AR 40–5 and AR 385–95. (3) Assist unit Aircrew Life Support Equipment shop with Class VIII support and survival education.

Check for evidence that the flight surgeon has visited the ALSE Shop and assisted in training requirements.

20.00

Is the supporting flight surgeon a member of the Safety Council? (AR 385-95 Para. 3-4b) (AU)

Para. 3-4b. The CSC is organized by the ASO, chaired by the commander, and consists of the following unit personnel (if assigned), at a minimum: (1) Commander. (2) Operations officer (S-3). (3) Instructor pilot/standardization instructor pilot (IP/SP). (4) ASO. (5) Aviation maintenance officer. (6) ALSS manager. (7) Flight surgeon. (8) Senior unit NCO (1SG/CSM). (9) Aviation safety NCO (ASNCO). (10) Other personnel designated by the commander, as required.

Check council appointments and flight surgeon participation in the safety council.

21.00

Does the flight surgeon take part in safety meetings and training? (AR 385-95, Para. 1-6g (11), AR 40-3, Para. 3-6 (2) (3) (5)) (AU)

AR 385-95, Para. 1-6g (11) Take part in aviation safety meetings to educate aviation crewmembers on the aero medical aspects of flight. AR 40-3, Para. 3-6 (2)(3)(5) (2) Conduct aero medical briefings held for both officer and enlisted personnel at unit-level training or aviation safety meetings. (3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385–95 and AR 40–21. (5) Participate in unit field training exercises and unit day-to-day flight activities.

Check training documentation for flight surgeon participation.

22.00

Are the flight surgeon and or aviation physician's assistant incorporated into the unit Reading File? (AR 95-1, Para. 4-4) (AU)

Para. 4–4. Aircrew information reading files: Aviation units will establish and maintain aircrew training and information reading files per AR 385 - 95 and TC 1 – 210. Assigned aircrew personnel will read and remain familiar with these files.

Check for evidence that the assigned medical personnel are participating.

23.00

Are the supporting flight surgeon and or aviation physician's assistant on flight status with valid orders issued by the appropriate agency? (AR 600-105, Para. 3-9 and AR 600-106, Para. 2-2a (1)(3)) (AU)

Para. 3–9. Operational flying duty for flight surgeons a. Flight surgeons are considered on operational flying duty when placed on aviation service orders by TSG, CDR, ARPERCEN or CNGB. This duty entitles them to monthly Aviation Career Incentive Pay (ACIP).

Check for current flight status orders.

24.00

Does the flight surgeon and / or aviation physician's assistant meet the minimum flying hour requirements? (AR 600-105, Para. 3-10) (AU)

Para. 3–10. Flight surgeons annual minimum flying hours a. Flight surgeons assigned to flying duty must be credited a minimum of 4 hours per month in any military aircraft for active duty and 2 hours per month for RC to qualify for monthly ACIP (DODPM, part two). Rules pertaining to the banking of hours apply. Table 3–4 defines minimum hourly requirements for flight surgeons. b. Semiannual and annual minimum requirements will be reduced proportionately for those who begin or end flying during a certain flying year.

Check flight records to determine if assigned flight medical personnel met minimum requirements.

25.00

Does the Flight Surgeon participate as an air crewmember in each type of aircraft assigned to supported units? (AR 40-3, para 3-6f (6), AR 600-105, para 3-10d) (AU)

(6) Participate in an operational capacity as an air crewmember in flight in each type of aircraft assigned to supported units. An FS's operational capacity will include observing flight crewmembers, monitoring patients, etc. Flight will be in all flight environments—including emergency procedures—and mission profiles (for example, nap of the earth, night vision goggles, etc.) according to AR 95–1 and AR 600–105. Flight simulators should be used in units that cannot accommodate an FS as a crewmember due to training and qualification requirements (for example, those with attack and scout aircraft). The purpose of this simulator time is to ensure that FSs understand the mission profiles and stresses of the aviators that they support. Flight simulator time does not count toward meeting the aviation career incentive pay (ACIP) flying hour requirement.

Check for flight surgeon participation as a crewmember.

26.00

Does the Pre-accident plan address the duties and responsibilities of the flight surgeon? (AR 385-95, Para. 1-6g (5), AR 40-3 Para 3-6.f(3)) (AU)

Para. 1-6g (5) Ensure that the medical portion of the pre-accident plan is adequate. AR 40-3 Para 3-6.f(3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385-95 and AR 40-21.

Check flight surgeon responsibilities in the pre-accident plan.

27.00

Does the Flight Surgeon develop and periodically review the medical portion of the unit's Pre-accident plan as described in AR 385-95 and AR 40-21? (AR 40-3, 3-6f(3)) (AU)

(3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385-95 and AR 40-21.

Check flight surgeon involvement in developing the pre-accident plan.

B- CLINICAL DUTIES

QUESTION	QUESTION TEXT	REFERENCE TEXT	INSPECTION TECHNIQUE
1.00			

Are individual Health Records in the custody of a medical treatment facility or maintained by an appointed Health Record Custodian? (AR 40-66, para 1-5b, para 5-3) (AU)

1-5b. Army medical records, other than those of RCs, will remain in the custody of the MTFs at all times. RC records will remain in the custody of the appointed HREC custodian. This medical record is the Government's record of the medical care that it has rendered and must be protected. Upon request, the patient may be provided with a copy of his or her record, but not the original record. Only one free copy may be provided to the patient. Procedures should ensure conscientious Government control over medical records for good medical care, performance improvement, and risk management. **5-3. For whom prepared and maintained** HRECs will be prepared and maintained for all Army members. This includes Active Army and RC members, and cadets of the U.S. Military Academy. ARNGUS and USAR HRECs will be prepared and maintained by the custodian of the personnel files. (These HRECs will be prepared in accordance with paragraph 4-1, but they will be filed in alphabetical sequence.) When transferred to Army custody, HRECs for members of the Navy and Air Force will also be maintained. HRECs for military prisoners will be kept as long as they are confined in U.S. military facilities.

Check record custody procedures.

2.00

Are individual Health Records physically stored to ensure security and confidentiality of the records? (AR 340-21, para 4-4) (AU)

4-4. Safeguarding personal information a. The Privacy Act requires establishment of proper administrative, technical, and physical safeguards to—(1) Ensure the security and confidentiality of records. (2) Protect against any threats or hazards to the subject's security or integrity that could result in substantial harm, embarrassment, inconvenience, or unfairness. b. At each location, and for each system of records, an official will be designated to safeguard the information in that system. Consideration must be given to such items as sensitivity of the data need for accuracy and reliability in operations, general security of the area, and cost of safeguards. (See AR 380-380.) c. Ordinarily, personal information must be afforded at least the protection required for information designated "For Official Use Only." (See AR340-17, chap IV.) Privacy Act data will be afforded reasonable safeguards to prevent inadvertent or unauthorized disclosure of record content during processing, storage, transmission, and disposal.

Check security of health records.

3.00

Is access to individual Health Records restricted to authorized personnel only? (AR 40-66, para 5-23) (AU)

5-23. Access to health records All personnel having access to HRECs will protect the privacy of medical information. (See chap 2.) The extent of access allowed to certain personnel is described in a through e, below. a. Medical personnel. AMEDD personnel are allowed direct access to HRECs for purposes of diagnosis, treatment, and the prevention of medical and dental conditions. They also have access to work for the health of a command and to do medical research.

b. Military members. If a military member requests information from his or her HREC or copies of the documents in it, it will be given to him or her. If the record is a special category record, see AR 340–21, paragraph 2–5. However, the failure or refusal of a patient to designate a physician to receive information from his or her health record does not relieve the Army of the obligation to eventually provide the requested information to the patient. In this circumstance, competent medical authority will institute and adhere to appropriate procedures to ensure that the actual or perceived harm to the patient by disclosure of the health record is minimized. *c.* Inspectors. Personnel inspecting MTF, DENTAC, or USAR records are allowed direct access to HRECs. These personnel include Inspector General personnel conducting Nuclear Surety Program and Chemical Surety Program inspections in accordance with AR 50–5 and AR 50–6 (AR 20–1); it also includes Defense Nuclear Agency inspectors conducting Defense Nuclear Surety Inspections in accordance with AR 50–5. Inspectors may have access to HRECs to evaluate the compliance of AMEDD personnel with regulations. All inspectors must respect the confidentiality of the HRECs they inspect. Inspectors do not have unlimited access to ASAP–OMRs in accordance with 42 USC 290dd-2. *d.* Mortuary affairs personnel. Mortuary affairs personnel are allowed direct access to the HRECs of personnel killed or missing in action. They may have access to extract medical and dental information needed by their service. *e.* Other nonmedical Army personnel. Nonmedical personnel may need information from a person's HREC for official reasons. These personnel include unit commanders; inspectors general; officers, civilian attorneys, and military and civilian personnel of the Judge Advocate General's Corps; military personnel officers; and members of the U.S. Army Criminal Investigation Command or military police performing official investigations. Official requests for specific information from the HREC or copies of documents in it will be sent to the MTF Patient Administration Division, DENTAC commander, or RC record custodian, who will determine what information, if any, will be supplied by the MTF. (See para 2–3a.) Persons designated as certifying and reviewing officials in accordance with the terms of the Personnel Reliability Program, in accordance with AR 50–5 and AR 50–6, are authorized to review medical records of candidates and members of the Personnel Reliability Program in conjunction with proper medical authorities. Access to ASAP–OMRs is limited. (See guidance in 42 USC 290dd-2.)

Check for restricted access to health records.

4.00

Does the unit commander ensure confidentiality of individual Health Records and patient medical information? (AR 40-66, para 2-2) (AU)

2–2. Policies governing the protection of confidentiality DA policy mandates that the confidentiality of patient medical information and medical records will be protected to the fullest extent possible. Patient medical information and medical records will be released only if authorized by law and regulation. *a.* Within DA, patient medical information and medical records may be used for diagnosis, treatment, and preventive care of patients. Patient medical information may also be used within DA to monitor the delivery of health-care services, to conduct medical research, for medical education, to facilitate hospital accreditation, and for other official purposes. *b.* Unless otherwise authorized by law or regulation, no other person or organization will be granted access to patient medical information or medical records. *c.* Any person who, without proper authorization, discloses a patient's medical information or medical record may be subject to adverse administrative action or disciplinary proceedings. *d.* Private medical information and medical records are often viewed by clerical and administrative personnel, such as secretaries, transcriptionists, and medical specialists. This access is authorized and necessary in order for an MTF to properly process and maintain information and records. However, the MTF commander will ensure that all persons with access to medical information or medical records are trained in their obligation to maintain the confidentiality and privacy of medical information and medical records. *e.* When medical information is officially requested for a use other than patient care, only enough information will be provided to satisfy the request.

Check local procedures to ensure confidentiality.

5.00

For Active Duty units, are Health Record files screened semi-annually against current personnel rosters? (AR 40-66, para 5-28b (3)) (AU)

(3) HREC files for active duty personnel will be screened semiannually against current personnel rosters to ensure that the MTF file holds only the records of personnel served by that MTF. When an HREC or medical form is held by the wrong custodian, MTF records personnel will send the documents to the current custodian.

Check for the screening procedures.

6.00

Does the flight surgeon ensure health records of aviation personnel are maintained appropriately? (AR 40-3, Para. 3-5a(2)) (AU)

Para. 3-5a (2). Flight surgeon clinical duties. a. Primary care. The FS will— (2) Ensure appropriate maintenance of medical records on all aviation personnel, including air crewmembers in non-operational assignments even if not on active flying duty (on flight status). He or she will maintain a tracking mechanism to ensure aero medical documents such as FDMEs, DA Forms 4186, and so forth, arrive at their proper destinations. He or she will also ensure aviation medical records are included in all supervising MTF health record (HREC) quality assurance programs.

Check health records to determine completion and correctness.

7.00

Do individual Health Records contain a properly completed DA Form 4186? (AR 40-66, Para. 5-21b(6)) (AU)

Para 5-21b (6) DA Form 4186 (Medical Recommendation for Flying Duty). File the most recent DA Form 4186. If the person is granted clearance to fly, file the most recent DA Form 4186 next, if any, that shows a medical restriction from flying. If a waiver has been granted for any cause of medical unfitness for flying, file the most recent DA Form(s) 4186 showing such waiver(s) next. File any additional DA Forms 4186 that the flight surgeon determines to be required as a permanent record next. (Enter "Permanent Record" in Remarks section.) Destroy other DA Forms 4186.

Check completed 4186s for correctness.

8.00

Does an aviation physician's assistant or non-flight surgeon, issue a DA Form 4186 to return a crewmember to flying duty only when a flight surgeon is not readily available, and is the DA Form 4186 properly annotated to confirm the flight surgeon giving the verbal or telephonic approval? (AR 40-501, Para. 6-11 j, k) (AU)

Para. 6-11, j. Personnel authorized to sign the DA Form 4186 are as follows. (1) Any physician or health care provider may sign DA Form 4186 for the purpose of restricting aircrew and ATCs from aviation duties when an aero medical DQ exists. (See b above and chap 4.) (2) Only an FS may sign the DA Form 4186 to return aircrew and ATCs to FFD. Recommended restrictions will be annotated in the Remarks block of DA Form 4186. (3) A non-FS medical officer or an APA under the supervision of an FS may sign the DA Form 4186 to recommend returning aircrew and ATCs to FFD when an FS is not locally available by either— (a) Obtaining case-by-case telephonic guidance from an FS. The name of the consulted FS will be annotated on DA Form 4186, and on an SF 600 (Health Record— Chronological Record of Medical Care) in the patient health record, according to AR 40-48. (b) In the case of an APA, having an FS review the medical record and cosign the DA Form 4186 within 72 hours. k. Forms of the other branches of the U.S. Armed Forces and host allied nations similar to DA Form 4186 will be accepted by the Army when aero medical support is provided by those Service and or nations and DA Form 4186 is not available.

Check for appropriate notations on the 4186s.

9.00

Does the Flight Surgeon interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly? (AR 40-3, para 3-5d(2)) (AU)

(2) Interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly.

Check to see if the flight surgeon is interviewing all newly assigned crewmembers.

10.00

Are Aircrew members informing the Flight Surgeon when they have participated in activities or have received treatment following which there may be flying restrictions, and are these events documented on a DA Form 4186? (AR 40-8, para 3b, AR 40-501, para 6-11b) (AU)

b. Aircrew members will inform their flight surgeon when they have participated in activities or received treatment following which flying restrictions may be appropriate.

Check procedures in the unit and look for violations.

11.00

Does the Flight Surgeon medically clear air crewmembers for further flight duty following temporary medical disqualification or after an aircraft mishap? (AR 40-3, 3-5d (4)) (AU)

3-5d(4) Medically clear air crewmembers for further flight duty following temporary medical disqualification or aircraft mishap. (5) Ensure timely evaluation of aviation personnel who are medically disqualified.

Check records for compliance.

12.00

Are current extensions for flight physicals (FDME) filed in individual health records IAW AR 40-501, para. 6-11i? (AU)

Para. 6-11. i. The validity period of the current FDME (see Para. 6-8) may be extended for a period not to exceed 30 days on DA Form 4186. After expiration of this extension, the aircrew member or ATC must complete the FDME and be medically qualified or be— (1) Administratively restricted from flying duties if no aero medical DQ exists and be considered for a non-medical DQ and FEB (AR 600-105). (2) Medically restricted from flying duties if an aero medical DQ exists. In some cases, temporary flying duties may be recommended on DA Form 4186.

Check health records for extension documentation.

13.00

Do individual Flight Records contain medical waivers and suspension recommendations and approval letters as applicable? (AR 40-501, para 6-10g)(AU)

g. Disposal of documentation. Waiver and suspension recommendation and approval letters will be filed in the individual health record and flight record.6-3. The forms and other documents used to maintain flight records are filed in DA Form 3513 (*Individual Flight Records Folder, United States Army*) (IFRF). Paragraph 6-4 discusses folder-labeling procedures for these forms. Figure 6-1 shows the recommended method of labeling. Table 6-1 shows retention requirements for DA Form 4186 (*Medical Recommendation for Flying Duty*). Table 6-2 shows how closeout forms are distributed. The following are used to maintain the IFRF (DA Form 3513)—

Check for appropriate copies of waivers in flight records.

14.00

Are Health Records filed alphabetically or in terminal digit order? (AR 40-66, para 5-28a) (AU)

a. HREC files. HRECs will be filed at the MTF or DTF (includes Family Health Center clinics authorized to provide primary care to active duty units and members) that provides military medical and dental care or with the RC health records custodian. If the member is assigned to an isolated unit without a servicing MTF or AMEDD personnel, the HREC will be filed at the unit under the custodianship of the commander. (See para 1-4b.) The records may be filed alphabetically or in terminal digit sequence. (See chap 4.) A chargeout system will be used when the HREC is temporarily removed from the record room. (See para 4-6.)

Check record filing system.

15.00

Are sign-out procedures established to maintain accountability of health records? (AR 40-66 Para. 4-6) (AU)

Para. 4-6. Record charge out system a. The current physical location or destination of each record must be known. A charge out folder will be put in the file when a record is removed for use. The type of folder used may be determined locally; however, DA Form 3444-series or DA Form 8005-series may not be used. (1) OF 23 (Charge-Out Record) or another charge out record will be put in the folder; this record will show where the medical record is located. If a charged-out record is later moved to another location, a "change-of-charge" must be submitted to the record custodian. (2) Any laboratory reports, x rays, or other reports that arrive while a record is charged out will be put in the folder until the record is returned. (3) Records will be charged out no longer than necessary. Records sent to in-house clinics will be returned the same day as the clinic visit. However, if the record is transferred to another clinic for a consultation the following day, a change-of-charge will be sent to the record custodian instead of the record. b. An automated record charge-out (CHCS) may be used to update a record tracking system (CHCS) using bar codes.

Check established procedures and ensure they are working.

16.00

Is a charge out folder put in the file when a Health Record is removed for use? (AR 40-66, 4-6a) (AU)

a. The current physical location or destination of each record must be known. A chargeout folder will be put in the file when a record is removed for use. The type of folder used may be determined locally; however, DA Form 3444-series or DA Form 8005-series may not be used.

Check sign out procedures.

17.00

Are procedures established for disposition of health records of personnel no longer assigned? (AR 40-66 Para. 5-28d (3)) (AU)

d. Handling stray records and forms. Stray records and forms found during the semiannual files review will be handled as described in (1) through (3), below. (1) The records and forms will be screened against the MTF or DTF files, including the suspense cards. Those files that can be identified (that is, matched with a record or suspense card) will be sent to the proper custodian. The letter of transmittal will cite the member's assigned unit. (2) When the proper custodians cannot be determined, the MTF or DTF will, if possible, access its Defense Enrollment Eligibility Reporting System (DEERS) MDRTS to obtain the current record

custodian. Otherwise, the MTF or DTF will make a list of the members to whom the records belong, giving each member's full name, SSN, and current unit of assignment if possible. (It is a requirement of the world-wide locator service that both the full name and SSN be included.) The list will be sent to the MILPO with a cover letter requesting that the names be checked. The local MILPO should determine the appropriate section within its organization to complete the required action on the list. (Some installations have In/Out Processing Sections where installations' rosters and clearance files can be checked; at other installations, these functions are handled in the consolidation of military personnel activities.) After the MILPO has searched its files, the list should be forwarded to the post locator or to the installation activity that maintains the worldwide locator file. The MILPO or post locator response will be kept by the MTF or DTF in a file (file number 40 (general medical services correspondence files)) for 1 year. (See table 3-1.) (See AR 25-400-2 for information on nonaction paper files.)

Check to ensure disposition procedures are established and that no extraneous records are present.

18.00

Does the flight surgeon's office retain a copy of the FDME and all enclosures for a minimum of two years? (AR 40-501, Para. 6-10 c, d) (AU)

Para. 6-10. Disposition and review of FDMEs c. Classes 1/1A and Initial Classes 2/2F/2S/4. Completed FDMEs (originals of DD Form 2807-1, DD Form 2808, aeromedical continuation sheet, interpreted EKG, and other supportive documents) accomplished for application to aviation and aviation medicine training programs will be forwarded through the procurement chain of command of the applicant to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333 for central aeromedical review and disposition. The FS's office will retain a copy of the FDME and all enclosures for a minimum of 2 years. In no case will the originals be given to the applicant or other individuals not in the procurement chain of command. The Commander, USAAMC must make a final determination of fitness for flying duties before Classes 1/1A/2F/2S/4 applicants may be accepted and assigned to Fort Rucker for aviation and aviation medicine training programs. d. Trained Classes 2/2F/2S/4. Completed Comprehensive and Interim FDMEs (DD Form 2808 and DD Form 2807-1, aeromedical continuation forms, interpreted EKG, and other supportive documents, may include consultations, EKG tracings, radiographs, coronary angiogram, etc., and, if applicable, Aeromedical Summary) will be forwarded directly to Commander, USAAMC, ATTN: MCXY-AER, Fort Rucker, AL 36362-5333, for central aeromedical review and disposition. The FS's office will retain a copy of the FDME and all enclosures for a minimum of 2 years.

Check to ensure the required records are maintained.

19.00

Do non-operational aviators' health records contain a current flight physical? (AR 95-1, Para. 2-1b, AR 600-105 Para. 3-1c) (AU)

Para. 3-1c. All aviators and flight surgeons, whether or not assigned to operational flying duty positions, must meet class 2 medical fitness standards for aviators and class 2F medical fitness standards for flight surgeons for flying duty (AR 40-501), and be issued a medical clearance on DA Form 4186, Medical Recommendation for Flying Duty. Flight surgeons who resigned from aviation service (AR 616-110) or who have been terminated from aviation service by TSG; CDR, ARPERCEN; or CNGB, are not required to maintain class 2F medical certification.

Check non-operational aviation personnel's records for current flight physicals.

20.00

Does the Flight Surgeon recommend medical termination from aviation service (permanent medical suspension) if the term of temporary medical suspension has or is expected to exceed 365 days? (AR 40-501, para 6-17h) (AU)

h. The FS will recommend medical termination from aviation service (permanent medical suspension) if the term of temporary medical suspension has or is expected to exceed 365 days. The FS will notify the immediate commander by DA Form 4186 and forward an Aeromedical Summary to Commander, USAAMC,

ATTN: MCXY-AER.

Check records for compliance.

21.00

Does the Flight Surgeon or unit track FDMEs from initiation until posted in the Health Record with a final disposition from USAAMA? (AR 40-501, para 6-10f) (AU)

f. Tracking. The flight surgeon or aviation unit will track FDMEs from initiation until posted in the health record with a final disposition by USAAMA. If disqualified, the flight surgeon and aviation unit will take action as per AR 600-105.

Check for proper tracking and disposition procedures.

C- AEROMEDICAL EVACUATION UNITS

1.00

Does a flight surgeon participate in the training air ambulance personnel? (AR 40-3, Para. 3-6d and Para. 3-6f (3), 13-3c(4) (AU)

Para. 3-6d Air ambulance operations. The FS will—Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. Para. 3-6f(3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan Para. 13-3c(4) Training of emergency medical technician (EMT) personnel shall be according to the Department of Transportation EMT National Standard Curriculum or equivalent to it and accepted by the National Registry for Emergency Medical Technicians (NREMT). EMTs working in pre-hospital EMS, to include both ground and air ambulance, shall possess and maintain current certification through the NREMT commensurate with the requirements of the positions to which currently assigned (that is, emergency medical technician-basic (EMT-B), emergency medical technician intermediate (EMT-I), emergency medical technician-paramedic (EMT-P)).

Check for evidence of flight surgeon participation in the required training.

2.00

Does the Flight Surgeon review reports of medical evacuations (run sheets) for appropriateness of the mission and care given? (AR 40-3, para 3-6d)

3-6d. Air ambulance operations. The FS will—(1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft.

Check for review of the run sheets.

3.00

Does the flight surgeon function as the medical technical advisor to the local air ambulance unit commander? (AR 40-3, para 3-6 (d))(AU)

d. Air ambulance operations. The FS will— (1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. (2) Participate in actual air evacuation missions as appropriate.

Check for evidence of flight surgeon participation in the required training.

4.00

Does the Flight Surgeon evaluate equipment taken aboard medical evacuation aircraft? (AR 40-3, para 3-6d)

d. Air ambulance operations. The FS will— (1) Function as medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft. (2) Participate in actual air evacuation missions as appropriate.

Check for established procedures.

5.00

Have the Medical Service Corps aviators (67J) successfully completed the Medical Evaluation Doctrine Course (2C-F7)? (DA Pam 611-21, para 3-21j (2)) (AU)

(2) *Special qualifications.* Must hold a baccalaureate degree from an accredited college/university in a discipline acceptable to The Surgeon General, be a graduate of the AMEDD Officer Basic Course and be selected for the Rotary Wing Aviator Course. Must successfully complete the Essential Medical Training for AMEDD Aviators Course (2C-F7 Course) and maintain qualifications for unrestricted utilization as an Aeromedical Evacuation Officer. Before entering the MAJ promotion window, officers must have successfully completed the AMEDD Officer Advanced Course and CAS3. To hold executive positions at the LTC and COL levels, must have successfully completed the U.S. Army CGSC and should possess masters degree from an accredited program acceptable to The Surgeon General in a discipline related to one of the AOC in the MFA 70. Specific duties and restrictions are referenced in table

Check for crewmember qualification.

6.00

Have commissioned officers in the rank of 1LT or above who are transferring to Medical Service Corps billets (67J) completed the AMEDD Officers Branch Qualification Course (advanced) 081-22MS? (DA Pam 350-59, para 4-15) (AU)

4-15. AMEDD Officer Branch Qualification Course (Advanced) 081-C22MS
a. *Objective.* To provide commissioned officers transferring to the AMEDD with AMEDD-specific instruction normally presented in the resident AMEDD OAC.
b. *Eligibility.* Commissioned officers in the rank of first lieutenant or above who have transferred into, or are in the process of transferring into, the AMEDD and who have completed an officer advanced course in a branch other than AMEDD.
c. *Curriculum.* 16 subcourses on interactive CDs.
d. *Subcourses.* MD0420, MD0482, IS7038, IS8720, MD0446, MD0447, MD0400, MD0478, MD0413, MD0405, IS7033, MD0430, MD0431, MD0460, MD0408, MD0424.

Check for course qualification documentation.

7.00

Is SACMS-VT (Semi-annual Combat Medical Skills Validation Test) administered at least twice a year with a minimum of four months between record events? (TC 8-800, preface) (AU)

The Army Surgeon General has directed that all 91W's, Health Care Specialists must validate skills proficiency semi-annually. Therefore SACMS-VT will be administered at least twice a year, with a minimum of 4 months separating record events. Commanders may administer SACMS-VT more than twice a year, but they must indicate beforehand when results are intended for record purposes.

Check for completion of validation test.

8.00

Are all 91W military occupational specialty (MOS) recertifying in accordance with National Registry of Emergency Medical Technicians guidance? (AR 40-68, para 4-3a (2))

(2) In specialties that are not licensed by the State, and the requirements of the granting authority for State registration or certification are highly variable, there must be validation by a national organization that the individual is professionally qualified to provide health care in a specified discipline. Examples of this are the National Commission on the Certification of Physicians Assistants (NCCPA) for physician assistants (PAs) and the National Registry of Emergency Medical Technicians (NREMT) for emergency medical technicians.

Check for compliance.

9.00

Does the commander ensure accountability, control, safeguard, and maintenance of medical materiel? (AR 40-61, para 1-5)

1-5. Automation application The policies established in this regulation apply to manual and automated medical logistics operations. Proponents of automated systems being developed for fielding will comply with these policies. Activities operating under an approved automated supply system will use the automated procedures and capabilities of the automated system to satisfy the policies prescribed in this regulation. **1-6. Recordkeeping requirements** This regulation requires the creation, maintenance, and use of specific records, which are listed in table 1-1. (See AR 25-400-2 for file numbers (FNs), descriptions, and dispositions.)

Check the control procedures.

10.00

Are medical equipment sets, kits, outfits, and tools (SKOT) for air ambulance operations accurately reported on the Unit Status Report? (AR 220-1, para 5-5)

5-5. Evaluating component part availability *a.* Reportable LINs having several components, for example, sets, kits or outfits (SKO) and/or medical materiel equipment sets (MMS/MES/DES/DMS/VES), will be reported as on-hand if property records show the LIN has been issued and at least 75 percent of each SKO non-expendable and durable items are present and serviceable. Do not count the set as on-hand, if more than 25 percent of the non-expendable and/or durable components are unserviceable, missing, depleted or require supply action under AR 735-5 (for example, report of survey). *b.* ALL RC units will exclude all expendable and durable MMS/MES/DES/DMS/VES component items that have a shelf life less than 60 months (shelf life codes of A-H, J-M, P-R or 1-9). AC, echelon III and IV medical units will exclude all expendable and durable items with a shelf life less than 60 months that are part of the Surgeon General's Centralized contingency programs. The list of this materiel is available in SB-8-75-S7 and can be accessed on <http://www.armymedicine.army.mil/usama>.

Check the unit status report for accurate reporting of equipment.

11.00

Are medical equipment sets, kits, outfits, and tools (SKOT) shortages identified and on a valid requisition? (AR 710-2, para 2-6)

2–6. Requesting supplies *a.* Commanders will ensure that equipment and components listed in the authorized column (of the MTOE and TDA) are on hand or on request. Where available, TAADS-based automated systems such as: Distribution Execution System (DES), Logistics Army authorization document system (LOGTAADS), SPBS–R, DPAS, and the SPBS–R/I TDA will be used to request MTOE/TDA items. For an ammunition basic load requested on a preapproved DA Form 581 (Request For Issue and Turn-In of Ammunition), but not on hand, the document number will be entered to the property book.

Check for the requisitions and check with the ARMS team supply for their results of the unit supply evaluations.

12.00

Does the unit have a hoist maintenance SOP? (AR 750-1, para 3-6b)

3–6. General policies *a.* An officer or civilian equivalent qualified in maintenance management will be appointed as maintenance officer, in writing, at each level of command. Maintenance officers will provide staff supervision of materiel maintenance operations within the organization. MTOE units that have insufficient officers for these duties may appoint a qualified noncommissioned officer as the maintenance officer. *b.* Standing operating procedures (SOPs) will be established and maintained by all Army organizations and activities performing maintenance operations. *c.* Maintenance support programs will be structured to meet materiel system readiness objectives as defined by AR 700–138.

Check with the ARMS maintenance evaluator or confirm a hoist maintenance SOP yourself.

13.00

Does the unit conduct required scheduled hoist maintenance per TM 55-1680-320-23 and P, para 2-8 and table 2-1?

3-2. The Army Maintenance Standard. The Army has one maintenance standard. Army equipment meets the maintenance standard when the following conditions exist...*(6)* Scheduled services are performed at the service interval required by the applicable technical publication.

Check documentation to see if prescribed maintenance is being performed.

14.00

Are log books properly maintained for each hoist? (DA Pam 738-750, para 5-10)

5–10. Equipment log book binder *a.* Units will keep all like historical forms in a binder (NSN 7510–00–889–3494). That is, all the unit's DA Forms 2408–4 go in one binder. The unit's DA Form 2408–9 Transfer Reports will go in one binder. When the combined forms are too large for one binder, divide them into two or more binders. *b.* The DA Form 2408–9 will normally need the following four binders: (1) Acceptance or Gain Reports. (2) Transfer Reports. (3) Usage Reports. (4) Repair Reports. *c.* Equipment logbook binders may also be used to hold forms required on a missile system while on dispatch when more forms are needed than can be kept in an equipment record folder. *d.* Units with six or fewer items of equipment may keep like forms in a binder or keep all the forms on an item of

equipment in a binder. e. U.S. Army Combat Equipment Group Europe (USACEGE)activities may also keep all the forms on a POMCUS item of equipment in a binder.

Check the log books or check with the ARMS maintenance evaluators.